Contraceptive usage in homeless women accessing a dedicated primary care service in Scotland, UK

Contraceptive usage in homeless women accessing a dedicated primary care service in Scotland, UK: A case note review

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ABSTRACT

Background
Of the 70,000 people experiencing homelessness in Scotland, at least 40% are women. Little is known about their contraceptive usage. Most pregnancies in homelessness are unintended and children are usually looked after in the care system..

Methods
A case note review of women's current contraceptive usage in a primary care service serving women experiencing homelessness in Edinburgh, Scotland. The service electronic database was searched for keywords relating to contraception to determine current usage, but also reproductive health, wider demographics and previous pregnancies.

Results
Of 174 women (16-55 years), 75 (43%) were recorded as using a contraceptive method. 49 (28%) were using long-acting reversible contraception (LARC), most of which was the contraceptive implant. However, 6/41 (15%) of the most effective LARC (intrauterine contraception and implant) was being used beyond its' expiry date. 34 (20%) had no mention of contraceptive use in their medical record and 32 (19%) were not using contraception despite being sexually active. 6 (3%) had been hysterectomised/female sterilisation. 26 (15%) were not sexually active. 179 of the 233 (77%) children mentioned in women's electronic records were recorded as being looked after out-with their care.
138/174 (79%) had current/ previous drug or alcohol misuse. 100/174 (57%) had a history of domestic violence or abuse (DVA). 22/174 (13%) were involved/had been involved in sex work.

Conclusions

Primary care services need to give greater attention to the contraceptive needs of homeless women to empower them to become pregnant when the time is right for them and prevent the consequences of unintended pregnancy and homelessness.

TEXT BOX KEY MESSAGES

- Under half of the women accessing a dedicated primary care service for people experiencing homelessness were documented as using contraception.
- Often the LARC methods in situ were being used beyond their expiry date.
- Given high risk of and consequences of unintended pregnancy, more opportunities to discuss contraceptive choices are required.

BACKGROUND

Across Europe women experiencing homelessness are often 'hidden' from services and receive less welfare support especially if they do not have dependent children (1). They are also vulnerable due to high rates of domestic violence (1,2). Of the 70,000 people experiencing homelessness in Scotland, at least 40% are women (3). The number of homelessness applications involving pregnant women or children continues to increase (2).

There is a paucity of literature regarding contraceptive usage in women experiencing homelessness worldwide and no studies in a primary care setting. In the United Kingdom (UK) a study interviewing 14 women accessing homeless shelters reported women found access to contraception services difficult. This was largely because of homelessness and complex lifestyle challenges but also due to the attitudes of staff providing services (4).

Studies in the United States of America (USA) report that there are very limited contraceptive services for women experiencing homelessness (5) and that these women may be more likely to use long acting reversible contraception (LARC) than the general population (6,7,8). UK and US contraception data is not directly comparable. Unlike the UK, contraception in the US is not always free. In addition, US studies classify LARC as intrauterine contraception devices (IUDs) and the contraceptive implant; whereas in the UK LARC may also refer to progestogen only injectable contraception. There is some evidence in the UK that women in areas of high socioeconomic deprivation are more likely to be prescribed LARC than women in more affluent areas (9,10,11). LARC, with low failure rates, may be an appropriate choice for these women given it is not user dependent and does not require follow up appointments (1,12).

The limited data on the prevalence of pregnancy in homelessness in developed countries indicates that it is at least double that of the general population and most pregnancies are unintended. (8,13). This is most likely due to reduced access to contraception and increased partner coercion(14,15). Despite most children born into homelessness being cared for in the care system, homeless women are less likely to terminate a pregnancy than the general population (13). There are complicated psychological challenges for women who have had children removed from their care which makes them at increased risk of repeated pregnancies (14,16, 17).
Women have very low rates of attendance at antenatal clinics and an increased likelihood of low birthweight and premature infants (16,18).. This may be in part due to having no fixed address but also due to domestic violence, substance misuse, criminal justice involvement, and mental health challenges that they continue to experience whilst pregnant(3,19).

Aims and objectives
The aim of this case review was to establish the contraceptive usage and wider demographics of women who were experiencing homelessness and accessing a dedicated primary care service in Scotland, UK.

METHODS

Setting

When homeless in the UK, women can access contraceptive services on the national health service (NHS) through sexual health services, primary care and third sector groups. The Edinburgh Access Practice is a primary care service supporting people experiencing homelessness in Edinburgh, Scotland. In addition to primary care with a dedicated women's clinic, including a midwife, patients can access mental health support, housing and social work alongside numerous co-located services, appreciating that patients may struggle to use services away from somewhere familiar. Advice and access to contraception are provided at all clinics. Implants are inserted at the practice but intra-uterine contraception is inserted at the local sexual health clinic. There is a high turnover of patients and many have multiple reasons that prevent them from exiting homelessness (3). Some women experiencing homelessness will be registered at other practices in the city, and many, possibly the most vulnerable not registered with a general practitioner (GP) at all (20).

Participants

The term homeless woman is defined at this medical practice as born biologically female and living in unstable accommodation (either living in temporary accommodation, such as a shelter or hostel, sofa surfing (staying with an acquaintance) or street sleeping) in line with Shelter's definition (21).

The study reviewed the records of women who were currently registered with the Edinburgh Access Practice and had used the service in the previous 6 months from November 2018. Women over 55 (above fertile age) were excluded from the study (22).

Design

Given many of the patients consult either infrequently or opportunistically, or have no mobile phone/unreliable contact addresses, as well as the topic having potential for being sensitive, we elected to analyse electronic patient records.

Patients were anonymised with a number code. A free-text keyword search was then used to search the practice electronic database (VISION) and secondary care communication. Records were searched for demographics -age, sex and type of accommodation, first language (as a proxy for ethnicity), reproductive history, contraceptive methods, reported gender based violence, substance misuse, sex work and pregnancies/children (see Supplementary file 1).

The most recent reported contraception was recorded and results tabulated to include total numbers of women using each method which could include more than one method. We then recorded the total number of women using each method as their most effective method of contraception. We conducted a descriptive analysis of both the demographics and contraceptive choices results.

Ethics

The study was approved as service evaluation as per the University of Edinburgh's ethical requirements, written in conjunction with the National Research Ethics Service of the Health Research Authority of Scotland. No modification of investigation,

treatment or other aspects of clinical practice was involved. The dataset was anonymised, and the code for each patient was kept in the practice computer system rather than with the dataset, to ensure confidentiality.

Patients and Public Involvement

Patients and the public were not consulted or involved in the design of the study.

RESULTS

Demographics

184 of the 920 patients registered and actively using the practice were women. 174 women were of reproductive ae (15-55). The mean age was 35 years (range 17-53). 3 were born biologically female but either lived as transmen or identified as non-binary.

Of the women under 55 years of age, 28/174 (16%) had a current or frequent history of street sleeping, and 165/174 (95%) were recorded as using temporary accommodation. 138/174 (79%) had an ongoing or past history of drug or alcohol misuse, 100/174 (57%) had a history of domestic violence or abuse (DVA) and 22/174 (13%) women had documented involvement in sex work. 8/174 (5%) women were documented as not speaking English.

Of the total 184 women using the service, 109 (59%) had had at least one child with a range of 0-8 pregnancies per woman. There were 233 children mentioned in the medical records, 179 (77%) of whom were currently in, or had been raised in foster care, adopted or raised by relatives.

Contraceptive use

75/174 (43%) had a record of currently using some form of contraception. As shown in Table 1, 49/174 (28%) women chose LARC (intrauterine contraception, implant or progestogen only injectable) as their main method. However, 6/41 (15%) of intrauterine contraceptives and implants were being used beyond their expiry date. Of women using LARC, the implant was the most common method used. Condom use was 14/174 (8%) and often reported as intermittent. Oral contraceptive pill (OCP) use was 12/174 (7%).

Table 1 also shows that 59/174 (34%) women either had no mention of contraception in their medical record or were not using contraception despite being sexually active. 140/174 (80%) women had had a discussion about contraception at some stage. For 125 of these women (72%), this conversation took place at the first visit to register at the practice or in the first 3 months after registration.

Table 1. Contraceptive usage in women experiencing homelessness

Current contraception	Total number using this method (N)	Total using as main method N(%)
IUD/IUS	8	8 (4.6)
Implant	33	33 (19)
Progestogen only injection	8	8 (4.6)
OCP	12	12 (6.9)
Condoms	25	14 (8.0)
Hysterectomised/ female sterilisation	6	6 (3.4)
Withdrawal	1	1 (0.6)
Not sexually active	26	26 (14.9)
No contraception despite being sexually active	32*	32 (18.4)
No record of contraception	34	34 (19.5)
Total	185	174 (100)

Table 1: Current contraception usage as recorded in electronic record. (IUD=Intra-uterine device, IUS=intrauterine system, OCP=oral contraceptive pill). *2 of these women were pregnant and 3 same sex partner.

DISCUSSION

Key findings and what this adds

This study was a case note review of homeless women's current contraceptive usage in a dedicated primary care service in Edinburgh, Scotland. We found under half of the women were documented as using contraception.

LARC use in this group is high compared with the general population, with over one in four of all women using LARC as their main method of contraception, compared with one in twenty in the general Scottish population of women of similar age (13).
Studies in the homeless population in the US concur that LARC use in homeless women is also considerable; 29% use in ever homeless women in Los Angeles and

14% in ever homeless US veterans compared with 8% if housed (6,7,8). This may be due to specific programmes/subsidies targeting these groups and as previously stated, it is unlikely that US and UK data is directly comparable. Increased use of LARC in socioeconomically deprived groups has also been found in Scottish prescribing data but also studies solely in primary care; which would exclude any increased LARC prescribing in post termination care (9,10,11). It is not clear whether this relatively high use mirrors what happens elsewhere in deprived groups or whether this pattern is unique to Scotland due to the paucity of literature in this field.

The majority of homeless women using LARC were using the contraceptive implant. In the most socioeconomically deprived areas of Scotland implant prescriptions were more common (26/1000) than the least socioeconomically deprived areas (15/1000) (11). The converse was true for intrauterine contraception (11). The implant was also the most common LARC used in a UK programme for women who had repeatedly had children taken into care (23). Previous studies in the homeless population in the US have shown a preference for intrauterine contraception but data is limited (6,7,8). Given implants were performed on site at the Edinburgh Access Practice, provider training and patient familiarity with the setting may have influenced this result.

Just under half of the women were either having sex without contraception or there was no record of contraceptive use. One in five women were not using contraception despite being sexually active. Although this result is similar to the UK national data (24), it is likely to be higher in our group due to the further one in five women where there was no record of contraception. Many women are subject to partner coercion/DVA/prostitution which alongside complex and chaotic lives may affect their decision on whether to use contraception and condoms (1,15,25). Condom use was low compared with the general population as found in the few other studies of contraception and sexual health in homeless women (15,24,26). Use of OCP was lower compared with other methods and the general population, the reasons for which are unclear but are likely to be influenced by the complex and chaotic lifestyles (8,24).

One in five women had no mention of contraception use in their medical record, despite electronic prompts and it being part of the practice new patient health assessment (health assessment offered to all people registering at the practice) Most consultation records were taken up with practicalities of being homeless alongside complex social, medical and psychological issues, leaving little time to discuss reproductive health. The high levels of DVA, and substance misuse in the women in this study are also recognised elsewhere in the literature as barriers to homeless women accessing contraceptive services (1,15,18) alongside multiple conflicting medical social and psychological factors (4,18). The levels of DVA in this study are likely to be underreported, indicated by previous studies into DVA and homelessness (3). One in twenty of the women did not speak English which is likely to increase the complexity of accessing contraceptive services. These competing priorities may go some way to explain why less than half of the women were using contraception and why more than one in ten of the most effective LARC (IUDs and implant) was being used beyond its' expiry date (8).

Study strengths and limitations

As far as we are aware this is the first study examining contraceptive usage of homeless women accessing a specialist primary care service for the homeless population and the first quantitative study of homeless women accessing contraception in the UK. This is a group that is both neglected by literature and services. The study is not a true reflection of contraception use amongst all women experiencing homelessness in the UK. Some women will be missed as they are registered with a different GP practice or are unable/choose not to access primary care or a specialised service (20). Other cities may have different levels of deprivation/demographics.

Although a thorough keyword search was done on all records, data may be missing for some women due to fragmented records, exacerbated by the fact that this population is so itinerant.

Implications for further research, policy and practice

There is a dearth of quantitative data on contraceptive usage for women experiencing homelessness (5,6,7,8). This study adds to that limited data but a more comprehensive picture is required.

This dedicated primary care setting is only going a small way to meet the contraceptive needs of women experiencing homelessness. Further research is required into how a specialist primary care setting can both enable and empower women experiencing homelessness to make appropriate contraceptive choices. Further qualitative research is required into what influences contraceptive choice in homeless women from the viewpoint of both patient and provider; specifically the higher uptake of LARC than the general population and whether any influences are unique to homelessness.

It would be useful to understand more about how women experiencing homelessness access contraception out with a specialised primary care service through addressing the role of outreach, sexual health services and non-specialist primary care.

More qualitative data is required in order to explore barriers to using contraception, as well as women's understanding of the consequences of pregnancy whilst homeless, including the impact of medical and social complexity, culture, language and literacy (4,15). It would be useful to stratify this by age, given adolescent homeless women may be even more vulnerable than older women.(13,20,25)

Further research is required, particularly in socioeconomically deprived settings regarding what constitutes 'an informed choice' as opposed to contraceptive 'use' and how best to discuss this choice in a sensitive manner (19,27,28). Incorporation of routine contraceptive counselling, alongside increased time allowance may help mitigate some of the disadvantages these women face (19,28). It is not clear what the impact of a women only clinic was however literature suggests that this is important and requires further exploration (1,5,15). It is important that clinicians are not coercive themselves towards LARC in this setting as opposed to empowering women in the

decision making process (17,23,25,,28,29). Rolling out routine contraceptive counselling to primary care nationwide may also benefit the most itinerant and possibly most vulnerable women. Competing priorities in both primary care and the complexities of homelessness will make this challenging.

Conclusions

As far as we are aware this is the first study examining contraceptive choices of homeless women accessing a dedicated primary care service for homeless population. It is also the first quantitative study of homeless women accessing contraception in the UK. Just under half of women were documented as using contraception. LARC use was comparatively high, in keeping with previous studies in similar populations although much was being used beyond its' expiry date. Giving women more opportunities to discuss contraception in a primary care setting could empower women to become pregnant when the time is right for them and prevent the consequences of unintended pregnancy in this group. However, this can be challenging in practice due to complex social and medical issues.

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Dr Katie Hawkins (KH) conceived the idea of the study. Eliza Montague-Johnstone (EM) helped design the study along with KH. KH and EM decided how the data would be anonymised and handled. EM performed the case note review and collated the data. EM collated the data for the results table from the notes review. KH wrote the introduction. Methods and results were written by KH and EM. Guidance regarding interpretation of results was sought from Professor Sharon Cameron (SC). Discussion was written by KH.SC and Professor Stewart Mercer proofread the paper prior to submission.

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Competing interests

There are no competing interests.

Data Availability

All data relevant to the study are included in the article or uploaded as supplementary information